## Emergency Relief Application Virginia AIDS Drug Assistance Program (ADAP)

**Client Last Name:** _____ **First Name:**_____

**Date of Birth:** _____**Social Security Number:** _____

**Temporary Virginia Address:** _____

**Local Contact Phone** #: _____ **Alt. Phone #:** _____

**Contact info for local agency/person assisting you in accessing services** (name & phone #)**:**

_____

**Previous ADAP State &, if known, Client ID#:** _____

**Permanent Address:** _____

**Prescribing physician information (**name, address, phone number, name of clinic – any info the client can recall)

_____

**Pharmacy where last ADAP medications were dispensed (**please provide as much information as possible, i.e.

pharmacy name, street address, city, phone number, pharmacist's name**).** _____

_____

**Do you have any allergies to medications?** (please circle one response) **YES NO**

**If YES, specify:** _____

**How much HIV medication do you have? (Number of days supply)**_____ **days**

**If none, how long have you been out of medication?** _____

**Referred for Primary Medical Care?** (please circle one response) **YES NO**

**If YES, provide date of referral:** _____**and where referred to**: _____

**By signing this form, I attest to the following facts:**

a. I meet the eligibility criteria for the State ADAP that I was originally approved in
b. I currently do not have third party coverage for prescription medications.
c. I understand that it is my responsibility to notify the local health department immediately if my/our income increases; if I relocate out of Virginia; or if my/our insurance status changes.
d. I understand that deliberately omitting or giving false information could cause me to be removed from the Virginia AIDS Drug Assistance Program.
e. I understand that in order to receive emergency assistance from Virginia ADAP, I hereby authorize the release of my medical information to Virginia ADAP, and authorize Virginia ADAP to share confidential information with my originating State ADAP, primary medical professionals, and any referring agency personnel in Virginia.
f. I understand that this approval is for temporary assistance, with a time limit of eight (8) weeks from the date of approval. I will need to complete a new client intake if continued assistance needed after that time.
g. I understand that this application is a legal document. My signature attests that all the information I have provided is true and correct.

_____

**Signature of Applicant (required)** **Date**

**Please fax this completed form, LHS-181(s), and written prescription(s) to 1-804-864-8050**

**For questions/issues regarding missing information, call the VDH ADAP Coordinator, Rachel Rees, at 1-804-864-7919**